

Welcome to

GASTON

FAMILY DOCS

Thank you for selecting Gaston Family Docs as providers for your health care needs. To help us meet those needs, please fill out this form as completely as possible. If you have any questions or need assistance, we will be happy to help you.

Patient Information (CONFIDENTIAL)

Date _____

Name _____ Birthdate _____ Male Female

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

SS#/SIN _____ Minor Single Married Divorced Widowed Separated

If Student, Name of School/College _____ City _____ State _____ Full Time Part Time

Patient or Parent/Guardian's Employer _____ City _____

Business Address _____ City _____ State _____ Zip _____

Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone _____

Person to contact in case of emergency _____ Phone _____

Responsible Party

Name of person responsible for this account _____ Relationship to Patient _____

Address _____ Home Phone _____ Cell Phone _____

Employer _____ Work Phone _____ SS#/SIN _____

Personal/Family History

Pharmacy name & address:

Do you or a family member have any of the following?

	Self	Mother	Father	Sibling		Self	Mother	Father	Sibling
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Joint Replacement or Implant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swollen ankles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fainting/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Troubles/Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy/Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Easily Winded	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Diseases	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
AIDS or HIV Infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recent Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Angina	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frequently Tired	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					

Allergies

Are you allergic to:

	Yes	No		Yes	No
Aspirin _____	<input type="checkbox"/>	<input type="checkbox"/>	X-ray Dye/Iodine	<input type="checkbox"/>	<input type="checkbox"/>
Cephalosporins (Keflex, Cefitin) _____	<input type="checkbox"/>	<input type="checkbox"/>	Local Anesthetics (novacaine)	<input type="checkbox"/>	<input type="checkbox"/>
Codeine/Codeine Derivatives _____	<input type="checkbox"/>	<input type="checkbox"/>	Latex	<input type="checkbox"/>	<input type="checkbox"/>
Erythromycins _____	<input type="checkbox"/>	<input type="checkbox"/>	Adhesive Tape	<input type="checkbox"/>	<input type="checkbox"/>
NSAIDS (Motrin, Aleve) _____	<input type="checkbox"/>	<input type="checkbox"/>	Seafood	<input type="checkbox"/>	<input type="checkbox"/>
Penicillins _____	<input type="checkbox"/>	<input type="checkbox"/>	Shellfish	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa Drugs _____	<input type="checkbox"/>	<input type="checkbox"/>	Metal (nickel, mercury, etc)	<input type="checkbox"/>	<input type="checkbox"/>
Tetracyclines _____	<input type="checkbox"/>	<input type="checkbox"/>			

General Medical History

Are you under medical treatment now?

Yes No

If yes, for what _____

Have you been hospitalized for any surgical operation or serious illness within the last 5 years?

If yes, explain _____

Social History

Most recent occupation: _____

Family members you live with: _____

Use tobacco? Yes No

Type: _____

Use controlled substances? Yes No

Type: _____

Consume alcoholic beverages? Yes No

Type/Frequency: _____

Consume caffeine? Yes No

Frequency: _____

Wear contact lenses? Yes No

Guns in home? Yes No

Helmet Use? Yes No

Seat belt use? Yes No

To be completed for children under 10 years of age.

	Yes	No
Seat belt use	<input type="checkbox"/>	<input type="checkbox"/>
Helmet use	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco/smoke exposure	<input type="checkbox"/>	<input type="checkbox"/>
Water _____ Public _____ Well	<input type="checkbox"/>	<input type="checkbox"/>
Electricity	<input type="checkbox"/>	<input type="checkbox"/>
Natural Gas	<input type="checkbox"/>	<input type="checkbox"/>
Telephone	<input type="checkbox"/>	<input type="checkbox"/>

Medications

Are you taking any medications?

Yes No

Please List:

Type/Dosage _____

Diet/Exercise History

My current diet is: satisfactory unsatisfactory

Concerns: _____

My current exercise/activity level is: satisfactory unsatisfactory

Concerns: _____

My current weight is: satisfactory unsatisfactory

Concerns: _____

I have have not previously used diet or exercise to gain/lose weight.

I have have not previously used medication or supplements to gain/lose weight.

Sexual History

Are you sexually active YES NO

If using contraception, what type:

- | | | | |
|---------------------------------------|--|--|---|
| <input type="checkbox"/> abstinence | <input type="checkbox"/> spermicide | <input type="checkbox"/> diaphragm | <input type="checkbox"/> condom |
| <input type="checkbox"/> cervical cap | <input type="checkbox"/> birth control pills | <input type="checkbox"/> Depo Provera injections | |
| <input type="checkbox"/> Norplant | <input type="checkbox"/> IUD | <input type="checkbox"/> Vasectomy | <input type="checkbox"/> tubal ligation |

If no contraception, please indicate the statement that best describes your current reproductive preference/experience.

- My partner and I are currently trying to conceive.
- My partner and I are unable to conceive.
- I am in a sexually active relationship and have no need or choose not to use contraception.

Pregnancy History

How many children: _____ Method(s) of Delivery _____

I understand I am financially responsible for payment in full for all services rendered with the exception of industrial injuries. I authorize the release of any medical or other information necessary to process this claim. More specifically, I authorize my doctors to release my medical records, if necessary, to other doctors, my medical insurance carrier, the Health Care Financing Administration (for individuals with Medicare), my employer or workman's compensation carrier if injury occurred on the job, or my auto insurance if the injury occurred in an automobile. I also request payment of insurance and/or government benefits be made to the provider.

Patient Signature

Date